DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/24/13

PRINTED: 01/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445277	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCMINN MEMORIAL NURSING HOME & REHAB CENTER	886 HWY 411 NORTH ETOWAH, TN 37331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to notify the	F 157	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert G Bolaher — TITLE: Nbt. Administrator — (X6) DATE: 2/4/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 Physician of laboratory results exceeding therapeutic range for one resident (#36) of thirty-seven residents reviewed. The findings included: Resident #36 was admitted to the facility on September 9, 2008, and readmitted on April 9, 2012, with diagnoses including Chronic Renal Failure, Pleural Effusion, and Chronic Obstructive Pulmonary Disease. Medical record review of a Protime/International Normalization Ratio (PT/INR) (lab test for blood clotting) dated December 24, 2012, revealed PT 23.0 (normal range 10-13), and INR 3.0 (normal range .80-1.20). Medical record review of a Nurse's Note dated December 24, 2012, revealed "...faxed Protime results to DR. (doctor)..." Medical record review of a Nurse's Note dated December 26, 2012, at 3:30 p.m., revealed "...Order for Coumadin 2 mg (milligrams) Sat (Saturday), Tue (Tuesday), Thur (Thursday), 4 mg all other days..." Medical record review of a PT/INR dated December 30, 2012, revealed PT 26.4 and INR 3.9. Medical record review of a Nurse's Note dated December 31, 2012, revealed "...Protime faxed to DR..." Medical record review of the Medication Administration Record (MAR) dated January 1,	F 157	1) A PT/INR was completed for Resident #36 on 1/7/2013. The physician was notified promptly upon receiving the results of the resident's PT/INR which was within the therapeutic range. 2) The facility has determined that all residents taking Coumadin therapy had the potential to be affected. 3) LPN #1 was counseled on 1/8/2013 by the DON addressing the circumstances that require notification of the resident's physician, legal representative or family member. This included notification during holidays and off hours. All charge nurses responsible for medication administration currently working have been individually reeducated about notification of the resident's physician, legal representative or family member including notification during holidays and off hours. A mandatory in-service concerning the notification of changes will be conducted by the DON on 2/5/2013 and 2/6/2013 for all licensed nurses PRN nurses and those on medical leave will be in-serviced before returning to work. 4) The DON or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to the appropriate people (physicians and families). The plan of correction will be monitored at the quarterly PI/QA meeting until such time consistent substantial compliance has been met.	2/8/2013

Robert Nicholson

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F 157	Continued From page 2 2013 through January 31, 2013, revealed on January 1, 2013, (MONDAY) Coumadin 4 mg had been given to the resident. Medical record review of a Nurse's Note dated January 2, 2013, revealed "...orders received for Coumadin dosage and frequency. Hold Coumadin X (times) 2 doses 1/2/13 and 1/3/13. Restart 4 mg M (Monday), W (Wednesday), F (Friday), and 2 mg T (Tuesday), TH (Thursday), Sa (Saturday) Su (Sunday)..." Review of facility policy, Anticoagulation Therapy, dated December 22, 2011, revealed "...If lab results exceed therapeutic range, the facility will "Hold" the anticoagulant medications until the physician has been notified and new order is received..." Interview with Licensed Practical Nurse (LPN) #1 on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, revealed the Coumadin had been given on December 24, 25, 31, 2012, and January 1, 2013, and had not been held. Continued interview at this time revealed LPN #1 had been the nurse responsible to notify the Physician and had not followed up until two days later. Interview with the Director of Nursing on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, confirmed the facility failed to notify the Physician of a lab result that exceeded therapeutic range for two days.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

Robert G Coleman

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F 241	Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain resident dignity for one resident (#27) during meal time of thirty-seven residents reviewed. The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Bipolar Affective Disorder and Confusion. Observation on January 7, 2013, at 12:05 p.m., in the dining room, revealed the resident sitting in a wheelchair at the table with three other residents. Further observation at this time revealed the other residents eating lunch. Observation on January 7, 2013, at 12:30 p.m., in the dining room, revealed Certified Nurse Aide (CNA) #1 served resident #27 a lunch tray. Further observation at this time revealed CNA #1 sat down and began feeding the resident. Interview with CNA #1 on January 7, 2013, at 12:35 p.m., revealed the resident was served after all other residents in the dining room because the resident required assistance to eat. Interview with the Director of Nursing (DON) on January 7, 2013, at 3:00 p.m., in the B-Wing	F 241	1) The CNAs involved were immediately in-serviced on the proper procedures for maintaining resident dignity during mealtimes. 2) The facility has determined that all residents requiring feeding assistance at meal times have the potential to be affected by this practice. 3) CNAs and other facility personnel involved in providing feeding assistance to residents have been reeducated on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. A mandatory formal in-service on dignity during meal times will be conducted on February 5 and 6, 2013 for all employees. A "Validation Checklist" is being completed for each individual whose duties involve feeding assistance to determine if he/she is performing the procedure correctly and will be completed by 2/8/2013 on all employees currently working. The checklist will be completed on PRN employees and others on medical leave upon returning back to work. 4) The Director of Nursing Services (DNS), or designee, will conduct random observations of staff during mealtimes over the next three (3) months to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility's practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed by the PI/QA Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	2/8/2013

Robert B Bolehan

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F 241	Continued From page 4 Nurse's Station, confirmed serving the resident last while the resident viewed other residents eating had not maintained the resident's dignity.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide social services adequate to meet the needs of one resident (#95) of thirty-seven residents reviewed. The findings included: Resident #95 was admitted to the facility on August 18, 2012, with diagnoses including Malnutrition, Generalized Weakness, and Depression. Medical record review of the quarterly Minimum Data Set (MDS) dated November 26, 2012, revealed the resident scored a fourteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and feelings of depression that occurred several times weekly. Medical record review of a Social Work Note dated November 28, 2012, revealed "...resident expressed more depressed ask nursing to notify the Dr. (doctor)..."	F 250	1) The social worker met with resident #95 on 1/9/2013 regarding her depression status, Resident #95 reported that the current medications are working and she is less depressed. 2) All residents in the facility have the potential to be affected by this practice. 3) The social worker has implemented a geriatric depression scale on all residents triggering for depression on the MDS and/ or for those stating to the social worker or other staff that they are down or depressed. A copy of this evaluation and a progress note written by the social worker is now being sent to the resident's physician for notification. Nursing will be notified by the social worker. The social worker will be following up with each resident within 72 hours to determine if the physician has initiated interventions and/or the necessity for further services. This new social services protocol will be shared with all staff during the mandatory in-service on 2/5-2/6/2013. 4) The DON will receive a weekly update from the social worker on residents who have newly triggered for depression on their MDS or by personal statement that they are down or depressed. MDS interviews will be audited by the Interdisciplinary Care Plan team weekly for compliance with social worker follow up.	2/8/2013

Robert B Bolahn

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F 250	Continued From page 5 Interview with the Social Service Director on January 9, 2013, at 12:35 p.m., in the Social Worker's Office, confirmed the Social Service Director had not followed up with nursing regarding the increased depression and the Physician had not addressed the residents increased depression.	F 250		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan for two residents (#82, #60) for activities,	F 279		

Robert B Belcher

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F 279	Continued From page 6 one resident (#22) for smoking, and three residents (#95, #59, #52) for discharge plans of thirty-seven residents reviewed. The findings included: Resident #82 was admitted to the facility on October 25, 2012, with diagnoses including, Senile Delusion, Volume Depletion, and Acute Renal Failure. Medical record review of the activity assessment dated November 6, 2012, revealed, "...interest list-time with family, movies (oldies), likes pets..." Medical record review of the care plan updated on November 9, 2012, revealed no care plan for activities. Observation on January 9, 2013, at 9:25 a.m., revealed the resident lying on a low bed with the television on a country music station. Interview on January 9, 2013, at 11:00 a.m., with the Director of Nursing, at the nurse's station, confirmed the care plan did not include activities. Resident #60 was admitted to the facility on May 8, 2008, with diagnoses including Peripheral Vascular Disease, Hypertension, and Dementia with Delusions. Medical record review of the Minimum Data Set (MDS) dated August 25, 2012, revealed "...very important to do your favorite activity..." and the resident answered yes. Medical record review of an Activity Note dated	F 279	1) An Activities Plan was added to the care plans of Residents #82 and #60 by the Activity Director on 1/9/2013. The care plan of Resident #22 was updated on 1/10/2013 to include smoking goals and approaches. Care plans for Residents #95, #59 and #52 were reviewed and updated on 1/9/2013 and 1/10/2013 to include discharge plans, goals and interventions. 2) All residents currently in the facility and future admission have the potential to be affected by this practice. 3) All interdisciplinary care plan team members responsible for writing care plans were be re-educated on the facility's policy and procedure for developing and updating Comprehensive Care Plans on 1/16/2013 and all staff will attend a mandatory formal in-service on 2/5-2/6/2013. 4) Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s) and the interdisciplinary care plan team. All care plans will be updated as required by changes in the condition of the resident or at the request of the resident (or resident's POA). The Director of Nursing or designee, will complete random weekly audits of care plan for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the PI/QA Committee quarterly.	2/8/2013

Robert B Polk

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F 279	Continued From page 7 November 21, 2012, revealed "...resident attends activities of choice especially bingo/music..." Medical record review of the Care Plan updated November 23, 2012, revealed no care plan for activities. Observation on January 9, 2013, at 1:30 p.m., in the resident's room, revealed the resident sitting in a chair. Interview on January 9, 2013, at 3:40 p.m., with the Activity Director, at the B-Wing Nurse's Station, confirmed the current care plan did not include activities. Resident #22 was admitted to the facility on August 19, 2011, and readmitted on December 1, 2011, with diagnoses including Hypertension, Senile Dementia with Delusions. Medical record review of the Physician Orders dated January 1, 2013, through January 31, 2013, revealed "...Smokes w (with)/supervision..." Medical record review of the Care Plan dated September 22, 2012, revealed no Care Plan for smoking. Observation on January 7, 2013, at 2:15 p.m., revealed the resident outside smoking in the designated smoking area with supervision. Interview with the Director of Nursing (DON) on January 10, 2013, at 8:48 a.m., at the B-Wing Nurse's Station, confirmed the facility failed to develop a Care Plan with goals and approaches for smoking.	F 279		

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F 279	Continued From page 8 Resident #95 was admitted to the facility on August 18, 2012, with diagnoses including Malnutrition, Generalized Weakness, and Depression. Medical record review of the quarterly Minimum Data Set (MDS) dated November 26, 2012, revealed the resident scored a fourteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and an active discharge plan to return to the community. Medical record review of a Social Work Note dated August 24, 2012, revealed "...family would like resident in Florida...Social Worker to work with daughter to obtain Medicare and transfer to facility in Florida..." Medical record review of the Care Plan dated November 26, 2012, revealed no documentation related to the residents discharge plans. Interview with the Social Service Director on January 9, 2013, at 12:35 p.m., in the Social Worker's Office, confirmed the Care Plan dated November 26, 2012, did not address the resident's discharge plan. Resident #59 was admitted to the facility on November 9, 2012, with diagnoses including Congestive Heart Failure, Displaced Right Hip Fracture, Chronic Back Pain, Lumbar Spine Stenosis, Anemia, and Hypertension. Medical record review of Physician's Order Sheet, dated January 10, 2013, revealed the resident was to be discharged home on January 15, 2013.	F 279		

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F 279	Continued From page 9 Medical record review of the Care Plan, dated November 27, 2012, revealed no documentation related to the resident's impending discharge. Interview on January 10, 2013, at 12:27 p.m., at the nursing station, with the Director of Nursing, confirmed the Care Plan did not address the resident's impending discharge. Resident #52 was readmitted to the facility on October 8, 2012, with diagnoses including Acute Renal Failure, Paraplegia, and Pressure Ulcer. Medical record review revealed the resident was discharged to another nursing facility on November 21, 2012. Medical record review of the Care Plan dated October 21, 2012, revealed no documentation related to the resident's discharge needs. Interview on January 10, 2013, at 9:45 a.m., with the Director of Nursing, in the private dining room, confirmed the Care Plan dated October 21, 2012, did not address the resident's discharge needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		

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F 280	Continued From page 10 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update the care plan for the use of siderails for one (#82), failed to update the care plan related to a pressure ulcer for one (#63) of thirty-seven residents reviewed. The findings included: Resident #82 was admitted to the facility on October 25, 2012, with diagnoses including, Senile Delusion, Volume Depletion, and Acute Renal Failure. Medical record review of the Care Plan updated on November 9, 2012, revealed, "...Keep bed in lowest position, upper rails for assistance with repositioning..." Observation on January 7, 2013, at 3:56 p.m., revealed the resident lying on a low bed with four 1/4 siderails in the raised position. Interview on January 9, 2013, at 10:00 a.m., at	F 280	1) On 1/9/2013 the care plan for Resident #82 was updated to include the use of four half side rails to be used with the alternating air mattress on the bed. On 1/9/2013 the care plan for Resident #63 was updated to reflect the recent change and staging in a pressure ulcer. 2) All residents have the potential to be affected by this deficient practice. 3) The facility's MDS team and Interdisciplinary Team discussed the need for current accurate care plans on 1/15/2013 and 1/16/2013 at the skilled and LTC care plan meetings. All staff will attend a mandatory in-service for updating and revising care plans on 2/5/2013 and 2/6/2013. 4) Unit managers will review care plans daily Monday - Friday for those residents experiencing a change in status to ensure new or modified interventions have been addressed and documented regarding the resident's care. The Director of Nursing or designee will review a random sample of care plans weekly for six consecutive weeks to assure the review and revision of care plans. Results will be reviewed by the Risk PI/QA Committee.	2/8/2013

Robert B Polsher

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	445277	A. BUILDING _____ B. WING _____	01/10/2013

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F 280	Continued From page 11 the nursing station, with the Director of Nursing, confirmed the Care Plan was not updated to reflect the use of four siderails. Resident # 63 was admitted to the facility on June 9, 2008, and readmitted to the facility on November 17, 2012, with diagnoses including Diabetes Mellitus, Cellulitis Left Heel, and Generalized Muscle Weakness. Medical record review of the Care Plan dated December 20, 2012, revealed "...Impaired skin as evidenced by suspected deep tissue injury to buttocks...apply skin prep to buttock..." Medical record review of a Physician's Order dated December 18, 2012, revealed "...D/C (discontinue) calmosepline tx (treatment) to L (left) buttock begin skin prep to L buttock bid (twice daily) until healed..." Medical record review of a Physician Order dated December 29, 2012, revealed "...cleanse L (left) buttock area with w/c (wound cleaner) apply Neosporin ointment, cover with aquacel, change q (every) 3 days..." Observation on January 9, 2013, at 1:32 p.m., in the resident's room, revealed the pressure ulcer had become two separate wounds and the areas had opened. Interview with the Director of Nursing on January 9, 2013, at 2:00 p.m., at the B-Wing Nurse's Station, confirmed the Care Plan was not updated to reflect the current treatment or the stage of the pressure ulcer.	F 280		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=D	Continued From page 12 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to assess a pressure ulcer for one resident (#63) of thirty-seven residents reviewed. The findings included: Resident #63 was admitted to the facility on June 9, 2008, and readmitted to the facility on November 17, 2012, with diagnoses including Diabetes Mellitus, Cellulitis Left Heel, and Generalized Muscle Weakness. Medical record review of the Minimum Data Set (MDS) dated December 11, 2012, revealed the resident was at risk for developing pressure ulcers, had one unstageable pressure ulcer evolving, required extensive assist for bed mobility, transfers, and toilet use. Medical record review of the Pressure Ulcer Record dated December 18, 2012, revealed "...DTI (deep tissue injury) 3.5 x 5.0...has evolved,	F 314	1) On 1/9/2013 the RN Charge Nurse and the Physical Therapy Assistant conducted a skin/ wound assessment on Resident #63 to stage the opened area in the Deep Tissue Injury. At this time, the wound was measured, staged and reported to the physician. Treatment was continued as ordered. Appropriate revisions were made to the care plans by the ADON to reflect all current pressure ulcer interventions. The ADON reviewed the revised care plans with all staff involved in the care of the resident on 1/11/2013. 2) All residents with wounds could potentially be affected by this practice. *(Continued on the next page)*	2/8/2013

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F 314	Continued From page 13 open now..." Medical record review of the Care Plan dated December 20, 2012, revealed "...Impaired skin as evidenced by suspected deep tissue injury to buttocks...apply skin prep to buttock..." Medical record review of a Physician's Order dated December 18, 2012, revealed "...D/C (discontinue) calmoseptine tx (treatment) to L (left) buttock begin skin prep to L buttock bid (twice daily) until healed..." Medical record review of a Physician Order dated December 29, 2012, revealed "...cleanse L buttock area with w/c (wound cleaner) apply Neosporin ointment, cover with aquacel, change q (every) 3 days..." Medical record review of the Pressure Ulcer Record dated January 9, 2013, revealed "...Superficial Stage III pressure ulcer on periwound..." Observation on January 9, 2013, at 1:32 p.m., in the resident's room, revealed the pressure ulcer had become two separate wounds and the areas had opened. Review of facility policy, Skin Care Assessment Treatment and Prevention, dated September 1, 2001, revealed "...wound will be measured and documented in the event of a change..." Interview with the Director of Nursing on January 9, 2013, at 2:00 p.m., at the B-Wing Nurse's Station, confirmed the facility failed to stage the pressure ulcer when it opened on December 18,	F 314	*(Continued from the previous page)* 3) The facility policy regarding Pressure Ulcer Prevention and Pressure Ulcer staging was reviewed to clarify when deep tissue injuries are to be staged. Changes in wounds are to be communicated to the Physician. All nursing staff will be in-serviced by the DON on the guidelines NPUAP Pressure Ulcer staging on 2/5/2013 and 2/6/2013. PRN staff and any licensed nurses on leave will be in-serviced upon returning to work. 4) The unit manager will continue to review pressure ulcer risk assessments, skin assessments, interventions, and care plans on all residents daily Monday through Friday. The Director of Nursing will audit a minimum of 2 residents with wounds per month for three months, then 1 wound per month thereafter unless otherwise determined by the PI/QA Committee. Audits will be reviewed by the PI/QA. .	

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F 314	Continued From page 14 2012.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, review of Material Safety Data Sheets, and interview, the facility failed to follow the fcaility's smoking policy for one resident (#22) and to ensure the residents environment remained free of accident hazards on one of two hallways. The findings included: Resident #22 was admitted to the facility on August 19, 2011, and readmitted on December 1, 2011, with diagnoses including Hypertension and Senile Dementia with Delusions. Medical record review of the Physician Orders dated January 1, 2013 through January 31, 2013, revealed "...Smokes w (with)/ supervision..." Observation on January 7, 2013, at 2:00 p.m., revealed the resident sitting in an electric wheelchair at the door on B-Wing. Continued observation at this time revealed two cigars in the	F 323		

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F 323	Continued From page 15 cup holder attached to the electric wheelchair. Observation on January 7, 2013, at 2:15 p.m., revealed the resident outside smoking in the designated smoking area with supervision. Continued observation revealed the resident attempted to put the cigar out and another resident assisted. Further observation at this time revealed a staff member approached the residents, assisted resident #22 in putting the cigar out, placed the cigar in the cup holder of the electric wheelchair and the resident entered the facility. Observation on January 8, 2013, at 9:00 a.m., in the dining room, revealed the resident in the electric wheelchair and two cigars in the cup holder of the electric wheelchair. Observation on January 10, 2013, at 7:45 a.m., in the dining room, revealed the resident in the electric wheelchair and two cigars in the cup holder of the electric wheelchair. Review of facility policy, Resident Smoking, effective date March 1, 2005, revealed "...All residents who smoke will be individually assessed by the Care Plan Team...This will be documented on the Care Plan and put on the resident's chart...All smoking paraphernalia will be stored...by the staff...staff will keep all smoking paraphernalia until the designated smoking times..." Interview with Director of Nursing (DON) on January 10, 2013, at 8:48 a.m., in the B-Wing Nurse's Station, revealed no smoking assessment had been completed and the	F 323	1) Appropriate revisions were made to the care plan on 1/8/2013 to reflect the Resident #22 being able to smoke cigars and/or chew cigars. The DON spoke with the resident on 1/8/2013 regarding the storage of his cigars in the smoke box instead of his cup on the mobility chair. On 1/9/2013 the DON spoke with the resident son regarding the resident's cigars to be stored in the smoke box instead of in the possession of the resident per facility policy. 2) All other residents who currently smoke could be affected by this practice. 3) All smoking materials for all residents who desired to smoke or chew are stored in a secure box in the nursing station. Residents will only have access to smoking materials during supervised smoke periods. A smoking assessment was completed for all residents who smoke on 1/23/2013. All staff will be reeducated on the facility smoking policy and smoke assessment forms at the mandatory staff meeting on 2/5/2013 and 2/6/2013. 4) The nursing home leadership team will review any requested changes or new requests by residents prior to approving the use of tobacco. The decision will be made a part of the residents care plan.	2/8/2013

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F 323	Continued From page 16 resident had been allowed to keep the cigars in the resident's cup holder of the electric wheelchair. Further interview at this time confirmed the facility failed to follow the facility's policy and procedure for resident Smoking. Observation on January 7, 2013, at 12:42 p.m., in the A-Wing housekeeping closet, revealed the door standing open and a sign on the door revealed "...keep door locked..." Further observation at this time revealed six quarts of tile grout protector (sealer), one quart of Virex (disinfectant), one quart of activate (enzyme presoak), one twelve ounce bottle of fire and ant killer (pesticide) one half full, one quart glass jar labeled 7 dust (pesticide) one fourth full, one gallon water seal (water proofing sealer) one half full, one sixteen ounce plastic bottle of resolve (carpet cleaner) one half full, two gallons of Mean Green (all purpose cleaner), and a twelve ounce bottle of Lysol (disinfectant). Review of the Material Safety Data Sheets (MSDS) revealed: 1) Tile grout protector revealed "...Health Effects: May be harmful if inhaled...avoid eye contact...Keep out of reach of children..." 2) Virex "...Hazards identification: Harmful or fatal if swallowed...Keep out of reach of children..." 3) Activate "...can irritate nose, throat, and lungs...keep out of reach of children..." 4) Fire and ant killer "...may be harmful if absorbed through skin...keep out of reach of children..." 5) Seven dust "...Hazardous to humans...if swallowed...keep out of reach of children..." 6) Water seal "...may cause headache, nausea, or dizziness...keep out of reach of children..."	F 323	1) The automatic door closer to the "A" Wing housekeeping closet was repaired on 1/8/2013 by the nursing home maintenance Department. There were no residents harmed. 2) Any resident who is mobile in the nursing home had the potential to be affected by the housekeeping closet door being open. 3) The nursing home maintenance Department will make a visual check of door closers quarterly and make the appropriate repair. All nursing home staff on duty were reeducated to check that cabinet and closet doors are locked and closed. This directive will be repeated to all staff during the mandatory staff meetings on 2/5 and 2/6/2013. 4) The nursing home administrator and DON will review the reports from maintenance and make a visual inspection during periodic rounds (M - F) in the nursing home. Staff will be instructed at the staff meeting to close and lock doors and report defective closers to the nursing home maintenance department by completing a work order slip and informing either the nursing home administrator or the DON. All staff are responsible to ensure that all cabinets and closet doors are locked and closed.	2/8/2013

Robert G Bolcar

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F 323	Continued From page 17 7) Resolve "...avoid contact with eyes...keep out of reach of children..." 8) Mean green "...keep out of reach of children..." 9) Lysol "...keep out of reach of children..." Observation and interview on January 7, 2013, at 12:55 p.m., in the housekeeping closet, with the Administrator, confirmed the chemicals and cleaning agents were not in a locked cabinet and the housekeeping closet should be locked.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

Robert B Baldwin

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F 329	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure unnecessary medications were administered for one resident (#36) of thirty-seven residents reviewed. The findings included: Resident #36 was admitted to the facility on September 9, 2008, and readmitted on April 9, 2012, with diagnoses including Chronic Renal Failure, Pleural Effusion, and Chronic Obstructive Pulmonary Disease. Medical record review of a Protime/International Normalization Ratio (PT/INR) (lab test for blood clotting) dated December 24, 2012, revealed PT 23.0 (normal range 10-13), and INR 3.0 (normal range .80-1.20). Medical record review of a Nurse's Note dated December 24, 2012, revealed "...faxed Protime results to DR. (doctor)..." Medical record review of the Medication Administration Record (MAR) dated December 1, 2012 through December 31, 2012, revealed on December 24, 2012, (MONDAY) Coumadin (anticoagulant) 4 mg had been given, and on December 25, 2012, (Tuesday) 2 mg had been given to the resident. Medical record review of a Nurse's Note dated December 26, 2012, at 3:30 p.m., revealed "...Order for Coumadin 2 mg (milligrams) Sat	F 329	1) The order for the medication prescribed to Resident #36 was reviewed by the physician. A PT/INR was completed Resident #36 on 1/7/2013. The physician was notified promptly upon receiving the results of the resident's PT/INR which was within the therapeutic range. 2) The facility has determined that all residents taking Coumadin therapy had the potential to be affected. 3) LPN #1 was counseled on 1/8/2013 by the DON addressing the circumstances that require notification of the resident's physician, legal representative or family member. This included notification during holidays and off hours and the coumadin protocol which included to hold coumadin when INR is high until new orders are received from the physician. All charge nurses responsible for medication administration currently working have been individually reeducated about notification of the resident's physician, legal representative or family member including notification during holidays and off hours and holding Coumadin when the INR is higher that the therapeutic range. An in-service concerning this issue will be conducted by the DON on 2/5/2013 and 2/6/2013 during the mandatory staff meetings. All PRN and charge nurses on leave will be in-serviced upon return to work. *Continues on the next page.*	2/8/2013

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F 329	Continued From page 19 (Saturday), Tue (Tuesday), Thur (Thursday), 4 mg all other days..." Medical record review of a PT/INR dated December 30, 2012, revealed PT 26.4 and INR 3.9. Medical record review of a Nurse's Note dated December 31, 2012, revealed "...Protime faxed to DR..." Medical record review of the MAR dated December 1, 2012 through December 31, 2012, revealed on December 31, 2012, (MONDAY) Coumadin 4 mg had been given to the resident. Medical record review of the MAR dated January 1, 2013 through January 31, 2013, revealed on January 1, 2012, (MONDAY) Coumadin 4 mg had been given to the resident. Medical record review of a Nurse's Note dated January 2, 2013, revealed "...orders received for Coumadin dosage and frequency. Hold Coumadin X (times) 2 doses 1/2 and 1/3/13. Restart 4 mg M (Monday), W (Wednesday), F (Friday), and 2 mg T (Tuesday), TH (Thursday), Sa (Saturday) Su (Sunday)..." Review of facility policy, Anticoagulation Therapy, dated December 22, 2011, revealed "...If lab results exceed therapeutic range, the facility will "Hold" the anticoagulant medications until the physician has been notified and new order is received..." Interview with Licensed Practical Nurse (LPN) #1 (responsible for administration and notification of	F 329	*Continued from the previous page* 4) The DON or designee, will conduct a random audit of five (5) residents that take Coumadin weekly for four (4) consecutive weeks. Unit Managers will continue to audit M-F all Coumadin flow sheets and report discrepancies to the DON. Results of the audits will be reported at the quarterly PT/QA committee meetings.	

Robert B Bolahan

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F 329	Continued From page 20 the physician) on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, revealed Coumadin 2 mg had been given on December 24, Coumadin 4 mg had been given on December 25, Coumadin 4 mg had been given on 31, 2012, and Coumadin 2 mg had been given on January 1, 2013. Interview with the Director of Nursing on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, confirmed the facility failed to hold the anticoagulation medication for four days and the resident received the wrong dose of Coumadin on December 24, and 25, 2012, and received Coumadin on December 31, 2012, and January 1, 2013.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to prevent a significant medication error for one resident (#36) of thirty-seven residents reviewed. The findings included: Resident #36 was admitted to the facility on September 9, 2008, and readmitted on April 9, 2012, with diagnoses including Chronic Renal Failure, Pleural Effusion, and Chronic Obstructive Pulmonary Disease.	F 333		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445277	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCMINN MEMORIAL NURSING HOME & REHAB CENTER	886 HWY 411 NORTH ETOWAH, TN 37331

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F 333	Continued From page 21 Medical record review of a Protime/International Normalization Ratio (PT/INR) (lab test for blood clotting) dated December 24, 2012, revealed PT 23.0 (normal range 10-13), and INR 3.0 (normal range .80-1.20). Medical record review of a Nurse's Note dated December 24, 2012, revealed "...faxed Protime results to DR. (doctor)..." Medical record review of the Medication Administration Record (MAR) dated December 1, 2012 through December 31, 2012, revealed on December 24, 2012, (MONDAY) Coumadin (anticoagulant) 4 mg had been given, and on December 25, 2012, (Tuesday) 2 mg had been given to the resident. Medical record review of a Nurse's Note dated December 26, 2012, at 3:30 p.m., revealed "...Order for Coumadin 2 mg (milligrams) Sat (Saturday), Tue (Tuesday), Thur (Thursday), 4 mg all other days..." Medical record review of a PT/INR dated December 30, 2012, revealed PT 26.4 and INR 3.9. Medical record review of a Nurse's Note dated December 31, 2012, revealed "...Protime faxed to DR..." Medical record review of the Medication Administration Record (MAR) dated December 1, 2012 through December 31, 2012, revealed on December 31, 2012, (MONDAY) Coumadin 4 mg had been given to the resident.	F 333	1) The order for the medication prescribed to Resident #36 was reviewed by the physician. A PT/INR was completed for Resident #36 on 1/7/2013. The physician was notified promptly upon receiving the results of the resident's PT/INR which was within the therapeutic range. 2) The facility has determined that all residents taking Coumadin therapy had the potential to be affected. 3) LPN #1 was counseled on 1/8/2013 addressing the circumstances that require notification of the resident's physician, legal representative or family member. This included notification during holidays and off hours and the holding of Coumadin when the INR is out of normal range. All charge nurses currently working and responsible for medication administration have been individually reeducated about notification of the resident's physician, legal representative or family member including notification during holidays and off hours and the holding of Coumadin when INR is above the normal range. A formal in-service concerning this issue will be conducted by the DON on 2/5/2013 and 2/6/2013. All PRN nurses and nurses currently on leave will be in-serviced upon return to work. 4) The DON or designee, will conduct a random medication administration and order verification audits weekly. Unit Managers will continue to audit M-F all Coumadin flow sheets and report discrepancies to the DON. Results of the audits will be reported at the quarterly PT/QA committee meetings.	2/8/2013

Robert B Patchen

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F 333	Continued From page 22 Medical record review of the MAR dated January 1, 2013 through January 31, 2013, revealed January 1, 2012, (MONDAY) Coumadin 4 mg had been given to the resident. Medical record review of a Nurse's Note dated January 2, 2013, revealed "...orders received for Coumadin dosage and frequency. Hold Coumadin X (times) 2 doses 1/2 and 1/3/13. Restart 4 mg M (Monday), W (Wednesday), F (Friday), and 2 mg T (Tuesday), TH (Thursday), Sa (Saturday) Su (Sunday)..." Review of a facility policy, Anticoagulation Therapy, dated December 22, 2011, revealed "...If lab results exceed therapeutic range, the facility will "Hold" the anticoagulant medications until the physician has been notified and new order is received..." Interview with Licensed Practical Nurse (LPN) #1 (responsible for administration and notification of the physician) on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, revealed Coumadin 2 mg had been given on December 24, Coumadin 4 mg had been given on December 25, Coumadin 4 mg had been given on December 31, 2012, and Coumadin 2 mg had been given on January 1, 2013. Interview with the Director of Nursing on January 8, 2013, at 4:00 p.m., at the B-Wing Nurse's Station, confirmed the facility failed to hold the anticoagulation medication for four days and the resident received the wrong dose of Coumadin on December 24, and 25, 2012, and received Coumadin on December 31, 2012, and January 1, 2013.	F 333		

Robert B Bolcher

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

Robert B Holden

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F 441	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure infection control practices were maintained for one (#27) of thirty-seven residents reviewed. The findings included: Resident #27 was admitted to the facility on December 26, 2012, with diagnoses including Diabetes, Hypertension, Fractured Femur, Dementia with Behavior, and Bipolar Disorder. Medical record review of a Physician's Order dated January 1, 2013, revealed "...Start INT (Intravenous needle)..." Medical record review of a Nurse's Note dated January 1, 2013, revealed "...placed IV (intravenous needle)...cath (catheter) in (right) hand..." Review of facility policy, Insertion and Maintenance of an Intermittent Infusion Device, revealed, "...The peripheral INT device shall be changed every 48-72 hours..." Observation on January 9, 2013, at 2:25 p.m. revealed the resident seated in a broda chair, in the hall, with a INT (intravenous needle) in the right hand. Interview on January 9, 2013, at 2:25 p.m. with Registered Nurse #1, at the nurse's station, confirmed the INT was inserted on January 1,	F 441	1) The nurse identified as Registered Nurse #1 was immediately reeducated on the proper procedures and facility policy for INT insertion, removal and changing. 2) The facility has determined that all residents requiring INT's have the potential to be affected. 3) All licensed nursing staff will be in-serviced 2/5/2013 and 2/6/2013 on the facility's *INT* policy and *Practice Guideline*. An in-service and review of the INT policy and procedure will be provided to PRN nurses and nurses on leave upon return to work. 4) The DON or designee, will complete random *Validation Checklists* of nurses with residents with an INT to ensure nurses are practicing in accordance with our facility's *Practice Guideline* and the resident's physician order and care plan. *Validation Checklists* will be reviewed by the PI/QA Committee.	2/8/2013

Robert B Bolcher

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F 441	Continued From page 25 2013, and was not changed per facility policy. Interview on January 10, 2013, at 8:45 a.m., with the Director of Nursing, at the nurse's station, confirmed the policy was not followed for the INT device.	F 441		

Robert S Polchan